American Hospital Association

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August 22, 2012

Via ECFS
Julie Veach
Chief, Wireline Competition Bureau
Federal Communications Commission
445 Twelfth Street, SW
Washington, DC 20554

Re: ***Further Comment on Issues in the Rural Health Care Reform Proceeding WC Docket No. 02-60***

Dear Ms. Veach:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Wireline Competition Bureau's Public Notice seeking additional comment on specific issues in the Federal Communications Commission's (FCC's or Commission's) proceeding to reform its Rural Health Care support mechanism.

THE FCC SHOULD MOVE QUICKLY TO ADOPT PERMANENT BROADBAND INFRASTRUCTURE AND SUPPORT PROGRAMS FOR RURAL HEALTH CARE PROVIDERS

The AHA urges FCC to proceed quickly with a final rule on the Rural Health Care program that will facilitate access to broadband services and infrastructure by America's rural health care providers. To maximize benefit, the AHA believes that the rule should streamline administrative requirements that have historically limited the program's success. As the nation moves forward with the adoption of electronic health records (EHRs), there is a growing digital divide between rural providers and their urban counterparts that must be addressed to ensure that all Americans can benefit from a broadband-connected health care system, regardless of where they live.

The needs for broadband support in rural areas are clear and growing. For example, adoption of EHRs and achieving the federal "meaningful use" regulations require access to sufficient broadband services.

However, while 29 percent of urban hospitals had adopted at least a basic EHR by fall 2011, only 19 percent of rural hospitals had done so.[1] Similarly, the Government Accountability Office recently reported that in 2011 acute care hospitals were more than twice as likely as critical access hospitals to have been awarded a Medicare incentive payment for successfully meeting the federal criteria for meaningful use of an EHR.[2]

The AHA urges FCC to streamline the Rural Health Care program for those who participate, so that the funds available can be fully deployed in support of a broadband-connected rural health care system. The AHA appreciates, therefore, the FCC's commitment to the Rural Health Care program and the Commission's willingness to learn from the pilot program. The pilot program has been beneficial in some areas, but its limited scope and burdensome requirements have restricted its usefulness.

While we understand that the FCC must take steps to ensure responsible oversight of federal funds, we urge that both urban and for-profit providers should be allowed to be participants in any consortia that apply for funding under the program – as long as controls are in place to ensure that rural providers receive the preponderance of the benefit. The Commission should move without further delay to adopt permanent broadband infrastructure and broadband service support programs for rural health care providers, consistent with these comments.

RULES FOR CONSORTIUM APPLICATIONS SHOULD MINIMIZE BURDEN ON APPLICANTS

The Public Notice poses many specific questions regarding the specific application process,[3] post-award reporting requirements,[4] and site and service substitutions[5] for consortium applications. Consistent with its 2010 comments in this proceeding,[6] the AHA urges the Commission to consider that overly complex and burdensome application and reporting requirements have been the primary reason that the Rural Health Care program historically has been underutilized. For example, hospitals report that the application requirements for individual members of a consortium are onerous and have resulted in significant delays. Individual participants are often small hospitals or rural health clinics with limited administrative capacity and technical resources. In addition, the structuring and management of communications services are not primary disciplines for health care facilities, and it can be challenging to find and pay for staff with this expertise. The AHA anticipates that its member hospitals that have participated in the Pilot Program will provide valuable input on the specific application processes and

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[1] Des Roches, et al. 2012. *Small, Teaching, and Rural Hospitals Continue To Be Slow in Adopting Electonic Health Record Systems*. Health Affairs 31, No. 5, May 2012.

[2] Government Accountability Office. *Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011*. GAO-12-778R. July 26, 2012. Available at: http://www.gao.gov/assets/600/593078.pdf.

[3] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, Public Notice, DA 12-166 (rel. July 19, 2012) (Public Notice). Section I.a, Consortium application process.

[4] *Id.* at Section I.b., Post-award reporting requirements.

[5] *Id.* at Section I.c., Site and service substitution.

[6] Letter from Rick Pollack, Executive Vice President, AHA, to Julius Genachowski, Chairman, FCC, WC Docket No. 02-60 (filed Sept. 8, 2010) (AHA 2010 Comments).

reporting requirements that will most efficiently assure a successful program. In finalizing detailed requirements, the Commission's touchstone should be to select the procedures that impose the minimum burden on applicants, consistent with responsible administration of the program.

SUCCESSFUL RURAL TELEHEALTH DEPENDS ON RURAL PROVIDERS' ABILITY TO FORM WORKABLE CONSORTIA WITH URBAN PROVIDERS

Many telemedicine networks connect rural providers to those in urban areas. Therefore, access to urban providers' resources will remain crucial for rural health care providers to benefit from broadband services, as the Commission has acknowledged. For this reason, the Commission should avoid overly onerous restrictions on the inclusion of urban sites in consortia.[7] At the same time, AHA strongly supports ensuring that the program's limited funding is used for the benefit of rural health care providers. We recommend that the Commission be clear and consistent in applying the test for rural benefit, whether that is the current principle of demonstrating "major benefit" or adoption of bright-line percentage. For example, the information needed to demonstrate "major benefit" should be clearly outlined, reasonable and minimally burdensome to collect. In addition, any bright-line percentage should be set at a level that would not exclude consortia that have proven successful in the pilots. Policies ensuring that funding predominantly benefits rural providers are more important than policies that address the make-up of the participants in the program.

THE REFORMED PROGRAM SHOULD ENSURE RURAL HEALTH CARE PROVIDERS' ACCESS TO BROADBAND SERVICE, INCLUDING LAST-MILE FACILITIES

The rules regarding eligible services and equipment must be crafted so that they are easy for rural health care providers to navigate, and to meet their demonstrated needs. [8] Although many rural providers lease broadband services, some construction is still needed. For many of the AHA's rural members, the ability to ensure access to "last mile" broadband connections to rural health care facility locations is a fundamental problem restricting broadband access. Therefore, the AHA supports the proposal to provide limited funding for the construction of facilities in the Broadband Services Program.[9] For some providers, financial needs and the costs of connectivity may make even the proposed 50 percent subsidy unaffordable. We recommend that the Commission establish a mechanism by which eligible health care providers can reasonably and promptly qualify for greater discounts if they have a demonstrated need.

As noted above, the structuring and management of communications services are not primary disciplines for health care providers – and rural health care providers in particular. Complex rules and administrative burden have previously limited participation in the program, despite demonstrated need for assistance. Steps to streamline should be taken in the application, reporting and competitive bidding requirements. The rules also should establish clear and binding expectations for timely review of applications and any supporting documents requested by the Universal Service

[7] Public Notice, Section II.
[8] *Id.* at Section III.
[9] *Id.* at Section III.c.

Administrative Company (USAC). In addition, the AHA agrees that the term "point-to-point" in the proposed rule could engender confusion, given the wide range of potential rural health care network typologies, and should be eliminated from the rule.[10]

Consistent with the AHA's prior comments in this proceeding, for-profit entities are an integral part of the rural health care system.[11] For example, 12 percent of rural hospitals are for-profit. The rules regarding the sharing of services between eligible rural health care providers and ineligible sites (e.g., for-profit facilities) should ensure that the program primarily benefits rural health care providers without restricting rural providers' ability to benefit from arrangements with ineligible providers.[12] In addition, the program will benefit from the ability of larger consortia to obtain lower prices by purchasing services together.[13]

THE COMPETITIVE BIDDING RULES SHOULD MINIMIZE BURDENS AND MAXIMIZE BENEFITS FOR RURAL HEALTH CARE PROVIDERS

The competitive bidding rules should be designed to minimize burdens on rural health care provider applicants that have limited experience in the construction and procurement of communications networks or services.[14] To that end, the AHA supports the proposals to:

- Exempt consortia from the request for proposal requirements if they are applying for less than a specified amount of support, such as less than $200,000;[15]
- Exempt individual (non-consortium) applicants and any applicants in areas where there is only a single broadband provider from the requirement to obtain competitive bids;[16] and
- Allow funding recipients to enter into multi-year contracts to lower administrative burdens year-to-year and increase the value of the services procured,[17] consistent with the AHA's prior comments.[18]

RURAL PROVIDERS HAVE EXTENSIVE BROADBAND NEEDS THAT ARE NOT BEING MET

The digital divide between rural and urban providers is large and widening. As noted above, a recent peer-reviewed article showed that information technology (IT) adoption varies widely based on the different characteristics of the health care provider. The article also showed that the differences across urban and rural providers grew between

[10] *Id.* at Section III.a.
[11] AHA 2010 Comments at 7-11.
[12] Public Notice at Section III.d.
[13] *Id.*
[14] *Id.* at Section IV.
[15] *Id.* at Section IV.a.
[16] *Id.* at Section IV.b.
[17] *Id.* at Section IV.c.
[18] AHA 2010 Comments at 5.

2010 and 2011.[19] The article is based on the AHA's annual survey of hospital use of health IT, which receives partial support from the Office of the National Coordinator for Health IT as a national monitoring survey. The government has a clear interest in ensuring that residents of rural areas are not denied access to the benefits of a broadband-connected health care system.

Rural providers will have a growing need for broadband as they move toward full implementation of EHRs, which is progressing on a rapid regulatory timeframe. For example, access to adequate, reliable, fast and affordable broadband are crucial prerequisites for using software-as-service or other cloud-based approaches to accessing and maintaining EHRs, as opposed to traditional server-based installations where software is implemented and maintained locally. Cloud-based solutions are very attractive to small health care facilities, including most rural providers, because they centralize upgrades, maintenance and security with the software vendor. Fewer technical experts are needed locally, lessening a key constraint on rural providers. Cloud-based solutions can be deployed only if the broadband available in rural areas is reliable and affordable; has built in redundancy; and is sufficient to handle large amounts of data at rapid speeds.

The future of health care will increasingly be conducted online, significantly expanding the use of broadband by rural health care providers. Indeed, the proposed rules for the next stage of meaningful use requirements emphasize sharing health information among providers that share the care of patients, and with consumers themselves. For example, sending discharge summaries electronically and hosting patient portals are currently being considered as requirements.[20] Without adequate broadband access, rural facilities cannot participate in health information exchange or provide patients with online access to their health information and other resources, such as health education materials. Use of online tools will soon become a routine part of health care, and it would disadvantage rural populations if their health care providers could not deploy them due to insufficient or overly-expensive broadband.

Beyond the meaningful use requirements, policymakers and payers increasingly recognize the financial and clinical benefits of telemedicine, which allows rural patients to be treated close to home. For example, the Medicare program is proposing to greatly increase the scope of preventive services that can be reimbursed if provided via telemedicine to include screening and behavioral therapy for conditions such as alcohol and substance abuse, depression and obesity.[21] The Veterans Health Administration (VHA) also has found significant benefit in telemedicine, and plans to increase emphasis on remote technologies to track patients in their homes, as well as to provide counseling and other services to veterans living in rural areas. VHA reports that it invested about $300 million in fiscal years 2011 and 2012 to expand access to health care through

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[19] Des Roches, et al. 2012. *Small, Teaching, and Rural Hospitals Continue To Be Slow in Adopting Electonic Health Record Systems*. Health Affairs 31, No. 5, May 2012.

[20] Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2; Proposed Rule.* Federal Register. March 7, 2012. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf.

[21] Centers for Medicare & Medicaid Services. *Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2013.* Federal Register. July 2012. Available at: http://www.ofr.gov/OFRUpload/OFRData/2012-16814_PI.pdf

telehealth programs.[22] Similarly, Michigan recently joined a dozen other states that require private insurers to reimburse telemedicine services.[23] Data from the AHA's annual survey of hospitals indicate that about 50 percent of hospitals have already implemented telemedicine services, and another 10 percent plan to do so within a year.

Hospitals also have found other ways in which a strong telemedicine infrastructure can support efficient operations that allow patients to be treated in their rural communities. For example, high-quality video connections support "telepharmacy" approaches to addressing a shortage of pharmacists. In telepharmacy, an urban pharmacist will supervise a pharmacy technician in an underserved rural community, ensuring patient safety and meeting state licensure requirements.[24] Future innovations also will provide technologies that can benefit rural health care providers, but they all require broadband connections. For example, telehealth "robots" could allow virtual consultations between rural patients and doctors at urban facilities.

In conclusion, the AHA urges the Commission to move quickly to finalize its ruling on the Rural Health Care program. The broadband needs of rural health care providers are real and growing. A program that provides significant support without heavy administrative burdens will ensure that all Americans, rural and urban, benefit from a technology-enabled health care system.

Thank you for the opportunity to share our concerns and comments. If you have any questions, please contact me or Chantal Worzala, AHA director for policy, at (202) 626-2313 or cworzala@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

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[22] http://www.telehealth.va.gov/newsletter/2012/021312-Newsletter_Vol11Iss01.pdf.

[23] http://www.crainsdetroit.com/article/20120702/FREE/120709986/snyder-signs-telemedicine-bill-issues-order-creating-autism-council#. July 2, 2012.

[24] See, for example, *Implementation of Telepharmacy in Rural Hospitals: Potential for Improving Medication Safety*. Upper Midwest Rural Health Research Center: December 2008. Available at: http://www.uppermidwestrhrc.org/pdf/report_telepharmacy.pdf.